Washington State Employee Assistance Program (EAP)
Network of Contracted Provider Recommendation and Closing

EAP Referral Number: **Date of Final Assessment:**

Presented Problem(s) (prioritize up to three)

___ Alcohol, Self
___ Alcohol, Other
___ Addiction, Self
___ Addiction, Other
___ Anger
___ Child/Parenting
___ Corrective/Disciplinary Action
___ Domestic Violence
___ Drugs, Self
___ Drugs, Other
___ Eldercare
___ Emotional/Psychological, Self
___ Emotional/Psychological, Other
___ Family/Marriage
___ Financial
___ Grief & Loss
___ Interpersonal
___ Job Loss
___ Legal
___ Medical/Physical, Self
___ Medical/Physical, Other
___ Organizational Change
___ Other
___ Other Work Problems
___ Recovery
___ Relationship/Conflict
___ Stress
___ Trauma/Incident
___ Vocational

Assessed Problem(s) (prioritize up to three)

___ Alcohol, Self
___ Alcohol, Other
___ Addiction, Self
___ Addiction, Other
___ Anger
___ Child/Parenting
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___ Domestic Violence
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___ Medical/Physical, Other
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___ Other
___ Other Work Problems
___ Recovery
___ Relationship/Conflict
___ Stress
___ Trauma/Incident
___ Vocational

Outcome of EAP Visits

Current Client's Condition	☐ Resolved	☐ Improved	☐ No Change	☐ Worse
Clients Presenting Issue to EAP	☐ Resolved	☐ Improved	☐ No Change	☐ Worse
Impact on Work	☐ Resolved	☐ Improved	☐ No Change	☐ Worse

Assessment Recommendation(s) (check all recommendations made)

☐ Alcohol/Drug Treatment
☐ Community Resource
☐ Financial Resource
☐ Human Resource
☐ Legal Resource
☐ Marital/Family
☐ Medical
☐ Mental Health
☐ None
☐ Other
☐ Other State Resources
☐ Self-Help/Support Groups
☐ Supervisor Management
☐ Union/Shop Steward
☐ Vocational

Disposition of Case

☐ Declined Recommendation
☐ Deteriorated
☐ Improved
☐ No Change
☐ Resolved
☐ Unable to Contact

Referral Information

☐ Client Accepted Referral
☐ Client Declines Referral
☐ In Network Insurance Benefit
☐ Out of Network Insurance Benefit

Upon completion of the final assessment the client was referred for ongoing counseling to the following.

Referral: Phone:

Referral: Phone:

Referral: Phone:

Did you offer yourself or anyone in your organization as a referral resource for further treatment beyond the EAP assessment visit? ☐ Yes ☐ No
If **yes**, the EAP case must be closed upon completion of the assessment.

If self referral was offered and accepted, you must complete the EAP Contracted Provider Referral Waiver form at the final EAP assessment session. The form must include two referrals to other clinicians with whom you have no financial interest and client's signature is required. You must inform client they are financially responsible for services rendered beyond EAP visits, and the client needs to verify that treatment providers are contracted with their health insurance benefits plan.

Reason for Self Referral

☐ Client Preference ☐ Geographic Location ☐ Other
☐ Clinical Experience ☐ Lack of Available Resources

Provider Signature: _____Credentials:_____ Date: _____

Submit this form to:
Department of Personnel
Employee Assistance Program
Attn: Contract Manager
1222 State Ave NE, Ste 201
Olympia, WA 98504